Mental Health

in Afghanistan

Mental health remains the orphan child of public health, and even more so in fragile states where health care systems are often non-existent or barely functioning. Psychosis and depression are still stigmatised, and governments of fragile states are often as weak as the whole country.

By Heidi Kingstone

Afghanistan is an interesting model. The government has named mental health as one of its priorities, the third on its list. The Ministry has not allocated sufficient funding, but these decisions are to a large extent controlled by external agencies, such as the World Bank and USAID, who refuse to invest in mental health. Currently the European Commission is the only large donor agency that is willing to fund mental health projects.

After nearly three decades of war, extreme poverty, and a continuing hostile and insecure environment every Afghan has a story. As depression is to a large extent caused by social factors, it's not difficult to understand why epidemiological surveys found symptoms of depression in the majority of Afghan women. They have terrible lives—87 per cent of Afghan women report domestic violence, 60 per cent of all marriages are still forced, and 57 per cent of all recent marriages involved girls under the age of 16, which is contrary to the law.

Stress affects all forms of health and well-being, physical as well as mental," says Michaela Hynie, Associate Director for Health Research at Toronto's York University. Genetic factors often underlie psychosis, so treatment for other mental disorders, like depression, is quite different. Inevitably it would elicit a different response than hearing voice or hallucinating, and lay beliefs about causes are often markedly different.

Sometimes they are confused. Temperatures in Afghanistan, a country with an inhospitable climate most of the year, plunge to well below freezing in winter. It was into these frozen conditions that a poor young woman found herself after she had been thrown out of the house by her father-in-law, like a worthless sack of rubbish, worth even less in his eyes. Undervalued and powerless as women are, with strict guidelines on where they can go and what they can do, she had to wait until this man allowed her back into the house. When he finally did, her fate was equally tragic. He held her feet to the fire, burning them. The pattern continued, and she went mad.

She had visions. In her dreams three djinns, fiery spirits of the Qur'an, would bring her the holy book on a white cloth and tell her she was a good woman. The hallucinations were her coping mechanisms. Initially the woman was treated for schizophrenia with drugs, but her 'cure' came from another source.

Dr Inge Missmahl, a psychoanalyst and mental health advisor to Ministry of Public Health, MoPH, based in Kabul, created a different template in helping to treat mental illness and depression. The treatment allowed her to acknowledge that she was right to feel aggressive toward her father-in-law who tortured her, to understand that her response was "normal". Missmahl told her she was a good woman, and that to suffer such abuse had nothing to do with any she had done.

Mental health workers are looking at taking new directions when tackling issues of depression and psychosis in fragile states where the problems are compounded by lack of human resources, lack of funds, public awareness and unsustainability. The western idea of looking for victims doesn't work. When Missmahl, first arrived in Afghanistan and asked women how they felt the answer was inevitably the same: "I have problems with my family." In a country where 90 percent of the population is illiterate, it is impossible to just empower women, then you meet with a brick wall. If men don't understand what is going on, and if mental health workers—psychiatrists, psychologists—don't understand what is going on outside their clinic the results will be unsustainable.

It is also almost impossible to get women from Afghanistan to talk about their feelings. Sometimes they will talk about concrete problems that they are having, but even then there is a reluctance to address these issues with strangers or outsiders to the family.

"Most women are in bad family situations," says Dr Peter Ventevogel, a Dutch psychiatrist and medical anthropologist with the NGO HealthNet TPO. "They cannot speak with words, so they do it with their bodies, perhaps not consciously." What he, and others found was that someone with mild depression can be treated by healers, who can help chase away the djinns.

This method is controversial on all levels. The Taliban doesn't like the idea of specialised mullahs, they consider any intervention except by god to be un-Islamic. Orthodox medicine uses different treatments. "Just because healers have been around for a long time doesn't mean they work," says Florence Baingara, a Ugandan psychiatrist based at Makerere University and former World Bank mental

health consultant. "FGM has been around for a long time too but we don't support that."

Statistics tell part of the story. In Afghanistan each doctor has 4000 patients, four minutes with each patient and the annual budget—excluding mental health which is not allocated any money—is $4.50 (R48) per person. While gender based violence is number three in the Millennium Development Goals, mental health is not on the list. Afghanistan remains dependent on external donors, but few NGOs deal with mental health.

There are two psychiatrists in Afghanistan, a country of 30 million people. One is out of the country and the other is minister of higher education. There are 15 psychiatric nurses—Afghanistan does not train psychiatric nurses—and one mental hospital. Training doctors outside of the country doesn't work. Due to low pay, feelings of helplessness and being overburdened, doctors don't want to go back.

Yet somehow the majority of people manage to cope and post traumatic stress disorder (ptsd) is less prevalent than would have been imagined. Dr Alia Ibrahim Zai, Director of the National Mental Health Directorate at the Ministry of Public Health remained in Afghanistan under the Taliban. Unable to work, forced to stay home, she had clandestine classes in English taught to her by a male neighbour. She was in London recently (September) at a conference held by the London School of Hygiene and Tropical Medicine together with HealthNet TPO.

"Depression is very common among men and women and mild and moderate cases are not considered disease and the initial approach is non medical. They believe that every thing comes from God."

One of the psychosocial counsellors in Kabul treated a woman who had attempted suicide five times. Her family had married her off to a man who was mentally challenged, which meant all her dreams were gone. Missmahl said she was surprised to find that after three months of treatment the woman had changed. What had happened was that she had accepted what God had given her at that moment.

Men suffer too, only it is acknowledged in different ways. There is a Pashtun saying that can be paraphrased like this: men gain prestige from their strength, women from their suffering. Missmahl encountered a man who had not spoken to his family for 20 years. He was brought into the clinic showing signs of anxiety and panic. He was too weak to walk on his own and had to be physically supported by his two sons, who had to sleep beside him. The root of the problem had started with the Soviet invasion. He had not been able to fulfil his duties as protector of his family, which he felt was a disgrace. It was a manifestation of the closeness he wanted with his family but was unable to express. When the clinic start 12 percent of clients were men, it has grown to 48 percent.

To deal with the issue effectively there has to be a commitment from the government, but government cannot do it alone, it needs the involvement of NGOs, traditional healers, volunteers and community leaders trained in local spaces, not fancy buildings. Once neglected in the development agenda, mental health is now being addressed. "We need to talk about models of care, packages that can be integrated into existing systems," says Ventevogel. "This does not have to be extremely costly. We have calculated that for less than half a dollar per capita we can install a system of basic mental health and psychosocial support in the eastern province of Nangarhar (Afghanistan) with more than a million inhabitants."

The issue of cultural attitudes towards mental health is fundamental and includes respecting how mental health issues have been treated in a community and whether we are talking about treatment for psychosis or depression. The former typically need medication, the latter may not. "Many cultures take a much more holistic approach to health and mental health and see causes in the environment and link it to spirituality," says Hynie. "Western medicine often fails to consider environment as a cause, and fails to consider the need of addressing the client's social context in decision-making and treatment. Western care providers need to know the local norms for treatment and know what can and would be used in addition to Western medicine."

Good psychosocial programming empowers people: instead of powerless victims people begin to take the initiatives in their own hands. "You can achieve spectacular results with relatively simple means such as support-groups, training of community leaders and women groups in helping skills, and training and supervising general health workers in basic psychiatric skills," says Ventevogel. A universal truism is that hope springs eternal, even in broken communities where there is no rationale to be hopeful. TBI